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ABSTRACT

This document contains four papers, discussing medical and sociocultural aspects of disability, presented at a national conference on the nonwhite disabled. In "Some Observations on Blacks and Physical Disability," Thornhill and Torres note the higher prevalence of physical disability among blacks and cite the example of more frequent lower extremity amputation. In "Sociocultural Aspects of Disability and Rehabilitation," M. Wilson reviews initiatives in rehabilitation, examines access of ethnic minorities to rehabilitation benefits, and compares cultural differences between ethnic minority groups and the white middle class. In his paper "Socio-Economic and Cultural Problems Affecting the Delivery of Rehabilitation Services to Hispanic Blind and Visually Disabled Individuals--Some Observations," R. Garza discusses the disabled Hispanic in terms of communication barriers, cultural background, family loyalties, and acceptance of rehabilitation. In "The Emerging Role of the Disabled Hispanics," A. Suazo considers the "double jeopardy" of disabled Hispanics--the economic, social, and educational problems of the entire population in addition to those problems suffered by the disabled segment. (CB)

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8 • Some Observations on Blacks and Physical Disability

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Abstract

This article reviews the available data on physical disability among blacks, who have a higher prevalence than any other racial group in the United States. The authors discuss lower extremity amputation as an example of a physical impairment particularly more common among blacks and which can cause severe disability. They conclude by stressing the great need for more information concerning disabling physical impairment and the urgent need for extensive and effective preventive measures.

According to reliable sources (Bowe, 1982; DeJong and Lifchez, 1983) the prevalence of physical disability among blacks is higher than among any other group in America. This is true for both sexes and across all age groups. The picture is particularly distressing for the "working age" population defined as persons 18–64 years of age. DeJong (1983) quoting his source, the 1976 Survey of Income and Education, reported 19.4% of this segment of the black population in its most productive years had a chronic health condition preventing participation in a major activity appropriate to their age. The comparable figure for the white population was 12.6%, while that for Hispanic persons was 10.6%. We know of no convincing evidence to suggest that this picture has significantly improved during the intervening years. Rather, we have concern that the increasing level of poverty since that study is being accompanied by the usual concomitants of poverty, including more disability.

National data on the prevalence of specific major physical impairments such as stroke, other cardiovascular disorders, head injuries, spinal cord injuries, and amputations according to race are limited. The available evidence, however, suggests similar patterns (Most and Sinnock, 1983; Moss, 1981; Young et al, 1982). A variety of factors likely contributes to the high prevalence of physical impairment and associated disability among blacks. These include such socioeconomic factors as low income and limited education. Health related factors include high rates of premature births, hypertension, diabetes, and physical trauma. This article further explores this scenario through the example of the lower extremity amputee.

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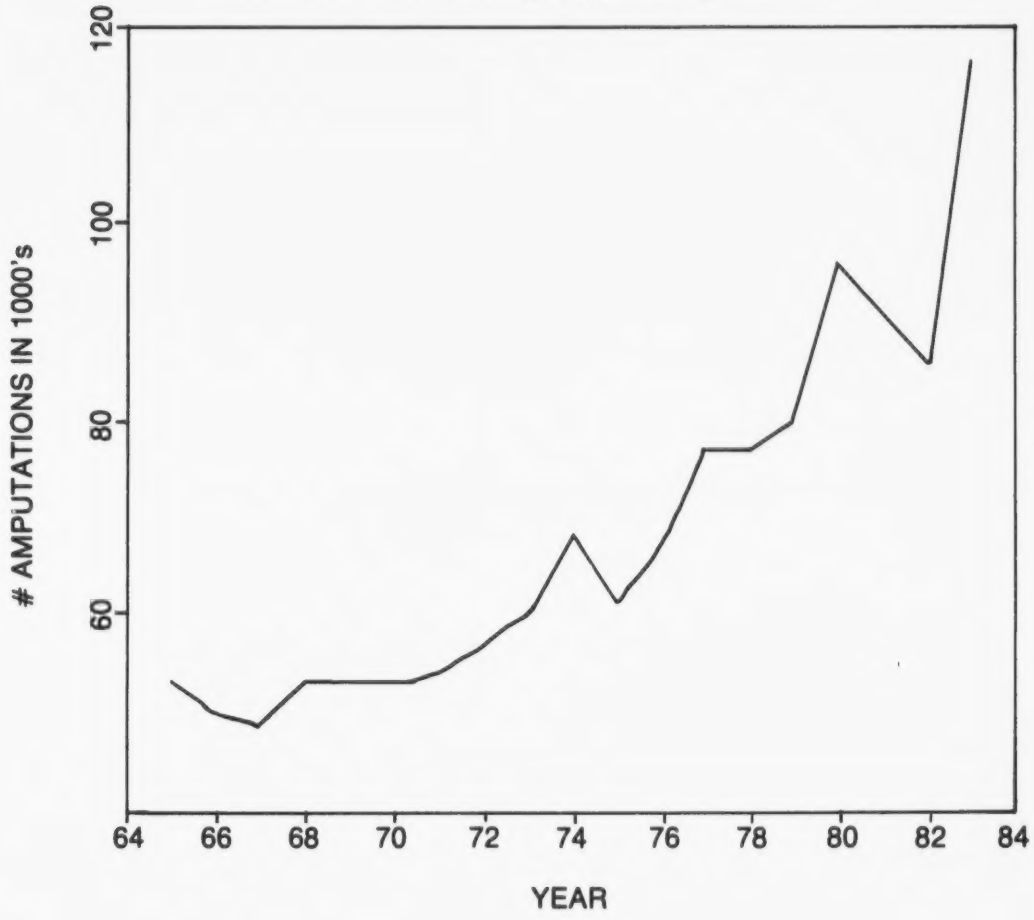
Illustrative of this public health problem is the lower extremity amputee—an example of serious physical impairment with associated disability. The major causes of lower extremity amputations are: atherosclerosis with or without diabetes and trauma. Malignant tumors and various forms of congenital abnormalities account for another small percentage. Recent reports indicate that the lower extremity amputee population has shown important changes over recent decades. According to the National Center on Health Statistics, data from the National Hospital Discharge Survey indicate that the size (Figure 1) of that population is increasing (1980). Other information suggests that the major cause—atherosclerosis—has shown an increased percentage among the various causes of amputation (Kay and Newman, 1975). A likely contributing reason for

FIGURE 1
Incidence of Lower Extremity Amputation by Year U.S.



Source: NCHS
Graph prepared by R. Prince

both changes is the increasing size of the elderly population.

As regards rehabilitative potential, the majority of patients who experience a major lower extremity amputation can successfully use an artificial limb, either with or without a walking device. Most become independently functional at many of their usual activities. Important determinants of rehabilitation success—particularly vocational adjustment—include physiologic age, type of previous employment, and how crucial the leg was to performance at the specific job. An example can be helpful. Two persons, both of whom may have experienced the same level of amputation, could have entirely different levels of vocational disability. A judge or teacher might experience little or no change in vocational ability to function. On the other hand, a farmer or messenger could have substantial vocational disability from the same anatomic impairment. Note also the implicit impact of educational achievement on level of disability and the importance of individualizing each rehabilitation assessment and plan.

Also, functional levels are influenced by the level of the amputation. Walking ability is substantially higher if the amputation is below the knee than if the leg is removed above the knee. This factor gains even greater significance when we realize that a number of the atherosclerotic patients eventually lose the other leg. Whereas, most bilateral below-knee amputees can walk with artificial limbs, it is rare for a bilateral above-knee amputee to accomplish this.

All available data suggest that the incidence of lower extremity amputation is higher among blacks than other racial groups. Workers from the Center for Disease Control (Most and Sinnock, 1983) have reported available data on rates of lower extremity amputations among diabetics, a particularly prone group. In New Jersey (1979) the rates were 95.5 per 10,000 diabetics for blacks and 62.2 for whites. The South Carolina (1973) rates were 94.4 for blacks and 41.6 for whites. Why is this so? Part of the reason is that many of the several factors contributing to the various causes of loss of limb are higher in blacks.

The factors responsible for the most common cause of this impairment—atherosclerosis—are in large part the same factors responsible for other serious impairments caused by disorders of the circulatory system, more specifically, progressive or sudden blockage of the arteries which supply oxygen to the heart, brain, and kidneys. The underlying disease, a form of arteriosclerosis known as atherosclerosis, is frequently referred to as the scourge of the Western society. This disease moves insidiously, sometimes explosively, causing heart attacks, strokes, kidney failure and gangrene necessitating amputation. Some of the factors contributing to the development and progression of this devastating process include: hypertension, cigarette smoking, diabetes, and diet high in animal fat.

The prevalence of many of these factors is substantially higher among blacks than whites. With the additional socio-economic factors of limited income, lower levels of educational achievement, and poor housing, the scenario becomes aggravated, causing an increase in the incidence of impairments and the degree of associated disability caused by these conditions. A similar picture of contributing factors, incidence and prevalence of physical impairments, and levels of disability can probably be constructed for most disabling conditions in blacks. They collectively underlie the devastating effect upon one-fifth of the black population in its most productive years—disabled.

This situation which has received almost no public and minimal professional attention represents a national disgrace for the most affluent country in the world. We as workers with the handicapped must take up the challenge posed by this dismal picture. We must intensify our efforts as advocates for those who are physically handicapped while we reinforce our various methodologies and develop innovative approaches to the improvement of function and prevention of disability.

Further, additional information must be developed to more precisely define the extent of the underlying disorders causing physical disability, determine the relative incidence and prevalence among the spectrum of physical impairments, and more carefully assess the impact upon human function due to these conditions. Such information can form a sound basis for the development of rational, effective strategies to turn this waste of human potential into a vast source of human achievement.

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9 • Sociocultural Aspects of Disability and Rehabilitation

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Abstract

This paper is a review of some of the interests and initiatives in rehabilitation that will foster a better understanding of social and cultural factors. It also examines the accessibility of ethnic minorities to rehabilitation and the benefits they received. Some factors of cross cultural relationships are listed, and the paper offers some implications to improve rehabilitation services for minority populations with handicapping conditions. The author provides Hall's (1973) "Map of Culture"—a teaching device portraying the influence of culture. There is also a comparison of cultural differences between ethnic minority groups and the white middle class in specific areas. Wilson concludes by suggesting some guidelines for the Howard University Project: need to emphasize cultural factors, need for non-racist practitioners and cross cultural training, need for determining the viability of alternate systems, need for research and dissemination of findings, and need for a synergistic and transcendent model.

REHABILITATION'S INTEREST IN SOCIAL AND CULTURAL FACTORS

Nearly twenty years ago, Mary E. Switzer (1965), the late Commissioner of the U.S. Vocational Rehabilitation Administration, challenged rehabilitationists to become more

sensitive to and effective with new clients in the rehabilitation system:

> . . . we face our greatest problems in the subtle things so essential to the rehabilitation process. In selecting disabled people for rehabilitation we could pick and choose 15 years ago. Today our state agencies are seeing people whom we really cannot communicate with at all. Sometimes we might as well be speaking Chinese as trying to reach disabled young Negroes in slum housing in our big cities, people who have been on relief for three generations. Too often we do not know how to talk to these people or how to make any real contact with them, and it takes a very dedicated and unusual type of professional individual who can emerge from a middle-class upbringing to really be effective in this kind of milieu. We need to know why this is and how we can overcome it—what can we do both short-range and long-range, if our society is to survive. (p. xi)

Indeed, during the 1960s and early 1970s, there was a great deal of activity aimed at examining the effects of racial differences and poverty on access to and development of persons through rehabilitation. Psychologists (Neff, 1971), sociologists (Sussman, 1965), and anthropologists (Chapple, 1970), with encouragement and funding assistance from the Vocational Rehabilitation Administration, began to study and provide insights on cultural differences. Rehabilitation counselor educators (Ayers, 1968; Dunn, 1967; Feinberg & Cohen, 1969; Kunce & Cope, 1969; Peterson, 1967; and Wilson, 1970) also examined, spoke on, and wrote about the effects of cultural differences on the rehabilitation process.

Also in the early 1970s, the National Rehabilitation Association, using experts and representatives from the following groups, published its Ethnic Differences Series: American Indians (Mackey & Blanchard, 1972); Black Americans (Edward, 1972); Mexican-Americans (Guerra, 1972); and Puerto Ricans (Hidalgo, 1972).

Throughout the years, there have been many conferences, some associated with the aforementioned efforts, to generate sensitivity to and understanding of ethnic minorities and their problematic relationships with the rehabilitation system and to solve the need for minority manpower in the professional and support work force (Ayers, 1974; Johnson & Wen, 1980). In addition, efforts have been made through demonstration projects to facilitate the access of minorities to the system and to meet their needs through modifications in the delivery system (Spencer, 1967; Virginia Department of Vocational Rehabilitation, 1973).

We are reminded that we still face problems in extending to ethnic minorities and culturally different persons the benefits of the rehabilitation system. The seminal study of Atkins and Wright (1983) concluded that unequal treatment of blacks was evident in all dimensions of the public rehabilitation process and that blacks entered and exited these programs in a disproportionately more disadvantaged status than whites. Other recent studies include the examination of severely disabled minorities in inner cities and the rehabilitation process (Royall and Corthell, 1981), the national study of the evaluation of vocational rehabilitation services to various racial and ethnic minorities by Lawrence Johnson and Associates (1981), and the current Howard University Model to Improve Rehabilitation Services for Minority Populations with Handicapping Conditions.

Even though these interests and initiatives were stimulated by and were concurrent with civil rights initiatives which led to the Civil Rights Act of 1964 and the civil rights legislation and regulations for the handicapped (Federal Register, 1977), minorities continue to be viewed as less than ideal clients for the system as it is organized, budgeted, staffed, directed, and evaluated. They experience problems in accessing and in receiving the developmental benefits available from participation in the system.

When educational and other institutions fail in the delivery of services to minorities, according to Hollins (1982, p. 41), five ideological reasons are offered as explanations:

(1) the deprivation thesis: blaming the client;
(2) the institutional racism thesis: blaming the professionals;
(3) the cultural conflict thesis: blaming ethnic cultural differences;
(4) the caste structure thesis: blaming social structure of society; and
(5) the class conflict thesis: blaming the capitalist economic system.

While each of these theses has some elements of validity, and proponents for these theses propose specific solutions to service access and delivery problems, e.g., new modes of service delivery to reduce the effects of racism and cultural conflict (Gellman, 1966; Solomon, 1976), the problem continues to exist and the rehabilitation services for ethnic minorities lag behind the access and benefits gained by white Americans.

SOME SOCIOCULTURAL INFLUENCES ON DISABILITY AND REHABILITATION

Rehabilitation can be viewed as a social system with rational purposes and procedures for converting disability into ability through rules, roles, and relationships within a cultural context (Chapple, 1970; Sussman, 1965). These rules, roles, and relationships may favor some clients over others, and it appears that middle-class white persons are favored over poor whites and ethnic minorities or culturally different persons.

But what are the cultural and sociocultural influences? For a good background for understanding cultural and sociocultural influences, I suggest the following books for study: *The Silent Language* by Hall (1973) and *Communicating with Strangers* by Gudykunst and Kim (1984).

An excellent orientation may also be gained from reading a chapter in a recent book on community health nursing that is titled "Social and Cultural Influences on Health Care" and authored by Bauwens and Anderson (1984). The concepts presented are as relevant to disability as to illness and to rehabilitation as to health care. A sampling of some of the content is illustrative:

> Culture enables us to interpret our surroundings and the actions of people around us and to behave in ways that make sense. "Culture consists of standards for deciding what is, what can be, how one feels about it, and how to go about doing it" . . . Some anthropologists conceive of culture as a set of rules. Each culture provides the individual with a set of rules for behaving and for interpreting the behavior of others. The set of rules can be compared to a cultural grammar—"culture is to behavior" as "language is to speech" (pp. 239-240).
>
> Culture influences our expectations and perceptions of symptoms; the way we label sickness; when, how, and to whom we communicate our health problems; and how long we remain under care. Because health and illness are shaped by cultural factors, there is variation in health care behavior, health status, and patterns of sickness and care within and between different cultures . . . (p. 244).
>
> If the health care provider and the client share the same beliefs and values, agree on appropriate treatment, and anticipate the same outcome, the client can be expected to comply with the provider's proposed health care. To the extent that the provider and client differ, the client's behavior can be expected to differ from what the provider desires, although the ways in which it may diverge cannot always be predicted (p. 244).
>
> People who have been reared in a group with common origins and a sense of identity often share basic concepts and attitudes toward health and illness as well as styles of behavior and concerns about the world. The effects of enculturation influence health-seeking behaviors and activities to prevent and treat disease. Nevertheless, there is individual variation, and appreciation of this helps to prevent the common tendency of health professionals and others to stereotype ethnic group members, which can be dangerous. If health workers are conversant only in bits of isolated aspects of health beliefs and behaviors, holism is lost and intracultural variation obscured. An accurate description of the culture and behavior of ethnic group members ideally provides an assessment of the range of behavior and the commonly held cultural beliefs and values. Without this knowledge, health professionals find themselves confronted with what appears to them to be strange and curious notions, and they feel the need to overgeneralize (pp. 244, 246).

It is important to understand that culture is pervasive and influences all of our roles, relationships, and meanings. Hall (1973), in his "Map of Culture" (pp. 193-199) presented here as Figure 1, provides a teaching

FIGURE 1.
A Map of Culture*

Primary Message Systems	Interactional 0	Organizational 1	Economic 2	Sexual 3	Territorial 4	Temporal 5	Instructional 6	Recreational 7	Protective 8	Exploitational 9
Interaction 0	Communication Vocal qualifiers Kinesics Language 00	Status and Role 01	Exchange 02	How the sexes interact 03	Places of interaction 04	Times of interaction 05	Teaching and learning 06	Participation in the arts and sports (active and passive) 07	Protecting and being protected 08	Use of telephones, signals, writing, etc. 09
Association 1	Community 10	Society Class Caste Government 11	Economic roles 12	Sexual roles 13	Local group roles 14	Age group roles 15	Teachers and learners 16	Entertainers and athletes 17	Protectors (doctors, clergy, soldiers, police, etc.) 18	Use of group property 19
Subsistence 2	Ecological community 20	Occupational groupings 21	Work Formal work Maintenance Occupations 22	Sexual division of labor 23	Where the individual eats, cooks, etc. 24	When the individual eats, cooks, etc. 25	Learning from working 26	Pleasure from working 27	Care of health, protection of livelihood 28	Use of foods, resources, and equipment 29
Bisexuality 3	Sex community (clans, subs) 30	Marriage groupings 31	Family 32	The Sexes Masc. vs. Fem. Sex (biological) Sex (technical) 33	Areas assigned to individuals by virtue of sex 34	Periods assigned to individuals by virtue of sex 35	Teaching and learning sex roles 36	Participation in recreation by sex 37	Protection of sex and fertility 38	Use of sex differentiating decoration and adornment 39
Territoriality 4	Community territory 40	Group territory 41	Economic areas 42	Men's and women's territories 43	Space Formal space Informal space Boundaries 44	Scheduling of space 45	Teaching and learning Individual space assignments 46	Fun, playing games, etc., in terms of space 47	Privacy 48	Use of fences and markers 49
Temporality 5	Community cycles 50	Group cycles 51	Economic cycles 52	Men's and women's cyclical activities 53	Territorially determined cycles 54	Time Sequence Cycles Calendar 55	When the individual learns 56	When the individual plays 57	Rest, vacations, holidays 58	Use of time-telling devices, etc. 59
Learning 6	Community lore—what gets taught and learned 60	Learning groups—educational institutions 61	Reward for teaching and learning 62	What the sexes are taught 63	Places for learning 64	Scheduling of learning (group) 65	Enculturation Rearing Informal learning Education 66	Making learning fun 67	Learning self-defense and to stay healthy 68	Use of training aids 69
Play 7	Community play—the arts and sports 70	Play groups—teams and troupes 71	Professional sports and entertainment 72	Men's and women's play, fun, and games 73	Recreational areas 74	Play seasons 75	Instructional play 76	Recreation Fun Playing Games 77	Exercise 78	Use of recreational materials (playthings) 79
Defense 8	Community defenses—structured defense systems 80	Defense groups—armies, police, public health, organized religion 81	Economic patterns of defense 82	What the sexes defend (home, honor, etc.) 83	What places are defended 84	The When of defense 85	Scientific, religious, and military training 86	Mass exercises and military games 87	Protection Formal defenses Informal defenses Technical defenses 88	Use of materials for protection 89
Exploitation 9	Communication networks 90	Organizational networks (cities, building groups, etc.) 91	Food, resources, and industrial equipment 92	What men and women are concerned with and own 93	Property—what is enclosed, counted, and measured 94	What periods are measured and recorded 95	School buildings, training aids, etc. 96	Amusement and sporting goods and their industries 97	Fortifications, armaments, medical equipment, safety devices 98	Material Systems Contact w/ environment Motor habits Technology 99

*E. Hall (1973) *The silent language.*

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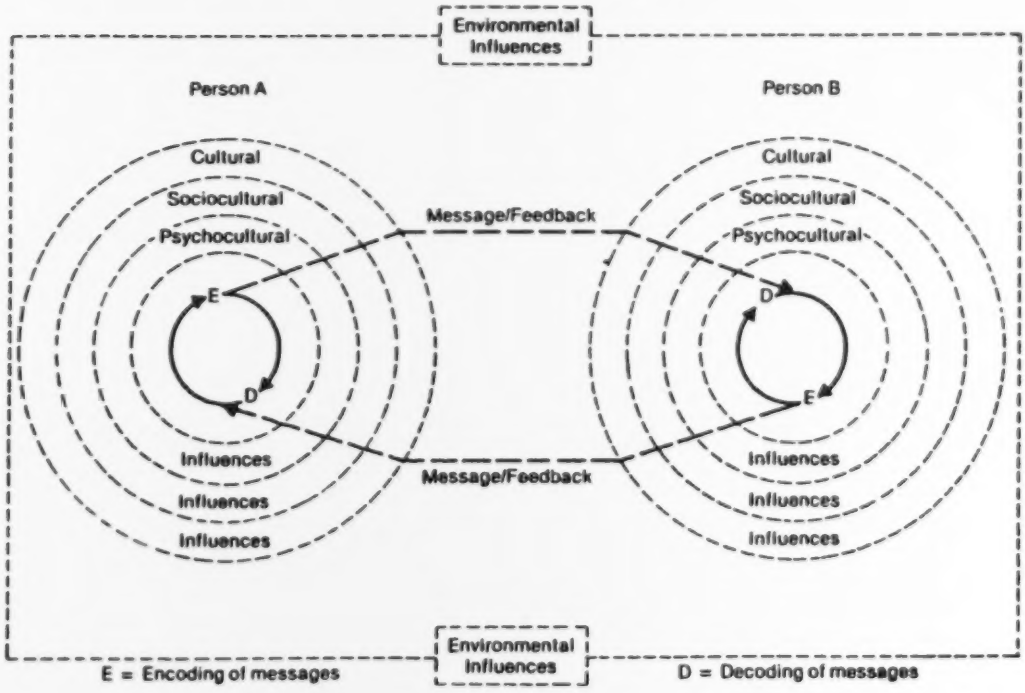
device for seeing the influence of culture on everything we do. The map enlightens us to the patterns, extensions, and results of interactions between the following 'Primary Message Systems' that give the dynamics and form of cultures: interaction, association, subsistence, bisexuality, territoriality, temporality, learning, play, defense, and exploitation. Except for the cells combining the interaction message system with the other message systems, the cells depict patterns, interactions, and extensions that are nonverbal, and this is why Hall refers to culture as "the silent language." According to Hall, culture is learned formally through precept and admonition, informally through modeling, and technically through oral and written instruction. Most meanings are learned early in life and are resistant to change.

While the map is limited by being two-dimensional, it orients us to the complexity and comprehensiveness of cultural patterns and rules, roles, and relationships related to those patterns. Indeed, think about how disabled minority persons fit into or are excluded from the patterns suggested in each cell. Think about what is needed to enable minority persons with disabilities to be viewed more favorably and to participate more meaningfully in American culture. While thinking in this manner may be difficult, it is essential if we are to understand how culture influences rehabilitation and the meaning of disability.

Figure 2 is a model of cross-cultural communication presented by Gudykunst and Kin (1984). The model indicates that a communicator is influenced by cultural influences or the cultural postulates, means, and ends held by the communicator; sociocultural influences such as group membership, role relationships, and interpersonal relationships; psychocultural influences such as cognitive processing patterns, including

FIGURE 2.
An Organizing Model for Studying Communication with Strangers



stereotypes, prejudices, ethnocentrism, and attributions; and both physical and psychological environmental influences. The exchanges of meanings between communicators are affected by these factors or influences, and feedback on meanings needs to be exchanged and clarified for accurate understanding to occur.

Let us now examine how value differences can influence communication. Figure 3 summarizes some value differences between ethnic minority groups and the white middle class (suggested by Sanchez, 1964). These differences are modal differences in that they tend to be more characteristic than not of the groups. For the ethnic minority groups, the values tend to be related to their lower socioeconomic positions, have some origins in their privations, and conflict with persons who control access to the things they need and want.

Let us examine how different assumptions about interpersonal relationships, time, relationship to nature, activity, and human nature influence cross-cultural communications. More specifically, let us examine how different perceptions of self, locus of control, and the costs of cultural change can operate in cross-cultural relationships.

Perception of Self. In his examination of American cultural patterns, Stewart (1972), indicates that the majority of Americans are taught to view themselves as separate, independent persons who have their own wishes, interests, and ambitions. They are taught to

FIGURE 3.

Cultural Differences Between Ethnic Minority Groups and The White Middle Class

Value Orientation	White Middle Class	Ethnic Minorities
Interpersonal or Relational	Individualism (i.e., emphasis of the individual ahead of any group considerations; strongly competitive individually and in groups).	Strong lineality (i.e., the vertically structured group hierarchy is stressed) and collaterality orientation (i.e., the horizontally structured group, "one for all and all for one" aspect of group loyalty, and existence of the extended family). Group rather than individual goals are stressed.
Time	Future time orientation (i.e., anything new is clearly better than anything old, and hopes are usually cast for the time to come).	Present time orientation (i.e., stress on the present with little or no regard for the future or past and, therefore, with scarce planning ahead of time).
Relationship to Nature	Man over or control of nature (i.e., nature can be tamed to man's will and control of his fate resides within his own skill and resources).	A subjugated to nature orientation (i.e., the stress is on the helplessness and weakness of man, factors that must be realized to gain any control at all over fate).
Activity	Doing orientation (i.e., striving for competence and achievement as measured by outside standards are important factors on the road to success).	Being orientation (i.e., the isness of behavior, the spontaneous inclination to act in accordance with one's mood, feelings, desires, and impulses).
Human Nature	A human but perfectible human nature orientation.	A mixed good and evil conception of human nature (i.e., roughly the characteristic Judeo-Christian notion).

value self-reliance and they assume all other persons see themselves this way.

Persons in most ethnic minority subcultures, however, are more group-oriented, prize individualism to a lesser degree, and see themselves as inextricable parts of the ethnic minority group and their family.

Rehabilitationists, socialized along majority middle-class lines in their professional development and orientation to the rehabilitation system, generally experience extreme difficulty in comprehending the thought processes of persons who do not share their conception of the self as an individual unit but instead as integral parts of a web of relationships.

Because of this difference in perception of self, ethnic minority persons are likely to be viewed not only as different but as undesirably different, unmotivated, and/or not cooperative for rehabilitation.

Locus of Control. A related concept is that of locus of control. Most professional rehabilitationists embrace middleclass values and see themselves as responsible for their own situations in life and assume that any changes in what they do will arise, ultimately, from decisions they themselves make.

Americans from lower socioeconomic groups, of which most minority persons are a part, however, do not share this notion because of the experiences of their group in trying to control their own destiny. Instead, they have learned to assume that other persons, social or spiritual forces, or whatever, like "luck," determine what happens to them. In many, many instances, disability and its treatment is viewed as being dependent upon the will of God or other spirits, and religion is not separated from illness, disability, health, prognosis, treatment, and outcomes.

As Sue (1978) argues, the idea of making their own decisions about their own futures does not make sense to them. Given this orientation, rehabilitationists are likely to see ethnic minority persons with disabilities as poorly motivated and high risks for a system which embraces the value of internal locus of control and pragmatic rationality. Many of these persons, therefore, are viewed as being mentally limited and doomed to remain dependent on public welfare, relatives, or their extended family.

Costs of Cultural Change. In his analysis of the problems encountered by social agencies and the socially handicapped in connecting and working together to attain improved conditions and functioning for the handicapped, Bredemeir (1966) suggests that the costs of change may be viewed as too high by both.

While middle-class persons are likely to view change as being in their self-interest with significant benefits for their individualism, ethnic minority persons may view the costs of change differently in terms of their current and secure relationships. Change may also generate fear of disappointment, anger, or even abandonment from the family. Change may also generate problems in new relationships which may result in failure to cope effectively (e.g. losing a job). The benefits of the status quo are clear and immediate, while the benefits of change are vague, distant, and risky.

Because of differential perceptions in the costs of change, ethnic minorities, in trying to deal with cultural conflicts, may appear to be unmotivated and uncooperative. Unfortunately, rehabilitationists, at least in their writings, have not dealt effectively with ethnic minority conflicts regarding loss of friends, loss of status, and loss of "face" as these relate to the rehabilitation process.

The analysis of the cost of change by ethnic minorities may also be tied in with the meaning which agencies of change have to them. As pointed out by Solomon (1976), black clients, for example, may not have firm convictions that practitioners in the agencies to which they have been referred have skills they can use in solving their problems, that establishing rapport across racial lines is particularly difficult, and that "expertise in dealing with their problems in living can be found in established social or mental health agencies since these same agencies have been perceived as accepting and perpetuating the negative valuation of blacks that is endemic in society" (p. 340).

SOME EFFECTIVE CROSS-CULTURAL RELATIONSHIP FACTORS.

While the record of effective cross-cultural transactions and interactions in rehabilitation is spotty, the literature does suggest some knowledge, attitude, and activity factors or competencies that can improve

service delivery—casefinding, intake, assessment, services, and outcomes—for persons motivated by ethnic minority or cultural differences.

In the casefinding or outreach and intake areas, rehabilitationists need knowledge, attitude, and skill competencies to deal with the following problems presented by ethnic minority persons and described by Bredemeier (1966) and Pape, Walker, and Quinn (1983):

- skepticism and mistrust of public service delivery systems as a result of their group's experience with the delivery systems
- lack of interest in service delivery systems because the disability is viewed as a punishment which must be borne for sins committed by potential clients or their parents
- lack of knowledge about or familiarity with rehabilitation service delivery systems and valid proof of the benefits for ethnic minorities
- ambivalence, resistence, and fear of devaluation, cultural conflict, and the reinforcement of lowered self-worth

Beyond casefinding and intake, these problems interacting with earlier negative and devaluative educational and testing experiences may frustrate the cooperation of ethnic minority persons in the assessment and planning stages. And if goals are established and services to reach those goals are begun, ethnic minority clients may have unresolved fears and conflicts regarding the likelihood of upward mobility and the security of the benefits to be gained by rehabilitation change.

In their analysis, Pape, Walker, and Quinn (1983) provided examples of facilitative and nonfacilitative interactions and transactions of rehabilitationists with ethnic minority clients— in this case, Asian, Black, and Hispanic Americans. Their analysis encouraged me to identify some of the effective knowledge, attitude, and skill competencies exhibited by rehabilitationists in relating to clients with ethnic minority or cultural differences.

By relating effective knowledge, attitude, and skill factors of rehabilitationists gleaned from the literature cited in this paper to some of the cultural, sociocultural, psychocultural, environmental, and communication components presented by Gudykunst and Kim (1984), I generated Figure 4 which emphasizes the need for rehabilitationists who work with disabled persons from ethnic minority and culturally different backgrounds to acquire and exhibit "a knowledge and understanding of cultural diversity factors as these relate to accurate problem identification, rehabilitation planning, and service provision" (Pape, Walker, and Quinn, 1983, p. 18).

FIGURE 4.

Effective Knowledge, Attitude, And Skill Factors of Rehabilitationists in Relating to Ethnic Minorities And Their Cultures

RELATING TO CULTURAL VALUES AND BELIEFS

- Exhibits cultural sensitivity and exhibits skills in getting, understanding, and utilizing culture-specific information.
- Respects culturally familiar protocols and conceptions of what is acceptable and desirable.
- Understands the freedom and constraints placed on persons by their cultural norms and values.
- Understands the potential danger points for culturally different persons generated by cultural conflicts and exhibits skill in resolving conflicts as soon as they arise.
- Knows work and other developmental opportunities in the client's home community and exhibits skill in referring clients and monitoring the helpfulness of the resources.
- Understands the developmental and defensive effects of indifference, ignorance, and devaluative attitudes and behaviors of majority persons on minority persons because of cultural differences.

- Understands and is able to cope with the fact that some disabled persons may be perceived in their own communities as being unsound, incompetent, and cursed for an alleged sin committed by themselves or by their parents.
- Demonstrates competence in relating to and working with ethnic minority persons in a variety of situations.

RELATING TO SOCIOCULTURAL FACTORS,
(INDIVIDUAL VS. GROUP, PERSONALISM, AND HIERARCHY)

- Understands family commitments and hierarchy.
- Demonstrates skill in a family-oriented approach and has a positive orientation toward the inclusion of the extended family in the helping relationship.
- Is favorably oriented toward family education and cooperation.
- Exhibits skill in using the extended family system for effecting cooperation and resolving conflicts.
- Knows and is skilled in selecting community resources that have cultural sensitivity and can be helpful.
- Understands ethnic minority reluctance to focus on reviewing childhood history.
- Exhibits a genuine concern for the ethnic minority client as a human being with assets and potentials to be valued.
- Understands the role status of the client, the family, and group and understands the client's need to consult with significant others before making decisions.
- Is appropriately formal or informal and directive or non-directive.

RELATING TO PSYCHOCULTURAL FACTORS,
(CATEGORIZATION, STEREOTYPES, AND ATTITUDES)

- Understands the importance of and attains with sensitivity an assessment of client needs within the social and cultural context of the client.
- Provides an early communication of accurate and warm empathy in the relationship with ethnic minority persons.
- Is sensitive to variation within groups.
- Is sensitive to and does not over emphasize test scores which have not been appropriately normed or validated for ethnic minorities.
- Has and communicates positive perceptions of the ethnic minority person's group and culture.
- Challenges negative stereotypic views of ethnic minority groups in an effective manner.
- Maintains a sensitivity to the individual as a unique being and to the culture as a whole.

RELATING TO CROSS-CULTURAL COMMUNICATION FACTORS
(LANGUAGE, NONVERBAL, EMOTIONAL, AND ENVIRONMENTAL COMMUNICATION)

- Demonstrates sensitivity to different language patterns and seeks to understand the client's mode of communication
- Adjusts to the language proficiency of the client.
- Is mature, genuine, and congruent in relationships with ethnic minority clients.
- Communicates accurate empathy early in the relationship. Uses action-oriented counseling techniques and approaches.
- Uses group counseling and group work (including family and extended family) in counseling ethnic minority clients.
- Uses nondevaluative and nonstereotypical verbal and non-verbal language in communicating with ethnic minority persons.
- Disseminates clear and valid information about services and their benefits to ethnic minority persons.
- Exhibits skilled use of plain, clear, and operational language.
- Exhibits comfort and skill in communicating with family members.
- Has bilingual capability.

- Is skilled in the use of interpreters.
- Is skilled in accepting and clarifying client values and in helping the client envision developmental possibilities within the value orientation.
- Exhibits good, basic, and stable nonverbal attending skills.
- Provides or interacts in a communication setting which has elements which are familiar and stimulating to ethnic minority clients.
- Understands and relates effectively to the time and spatial orientations of ethnic minority clients.
- Knows, understands, and uses culturally appropriate ways to enter and leave situations, including farewells, and convenient times to visit.
- Is sensitive to client feelings, particularly fears of failure and culture conflict.
- Is skilled in reducing test anxiety and increasing test-wiseness of clients from ethnic minority backgrounds.
- Demonstrates an awareness of the limitations, potential cultural bias, and problems with the use of tests and assessment procedures with ethnic minorities.
- Focuses appropriately on the here-and-now and how it relates pragmatically to the client's future.
- Understands and accepts the reluctance of ethnic minority persons to verbalize their feelings fluently and to be introspective.

RELATING TO REHABILITATION CHANGE AND CULTURAL CONFLICT

- Exhibits sensitivity to fears of failure and conflicts, including the intermittent and cyclical aspects, of ethnic minority clients.
- Understands client risks and fears (e.g. loss of disability income and/or welfare, friends, role status in the family community).
- Understands that the upward mobility of ethnic minorities through rehabilitation is risky and complicated with possible negative side effects.
- Understands the likelihood of the ethnic minority client feeling "culture shock" in new, unfamiliar places and situations related to rehabilitation and around different and unfamiliar persons—particularly authority figures and peers.
- Is cognizant of potential danger periods in the rehabilitation process for ethnic minorities and is skilled in the alleviation of conflict in situations as soon as they arise.
- Exhibits skill in action-oriented counseling techniques and approaches.
- Exhibits skill in using group counseling and group work (e.g. involving the extended family) in counseling ethnic minority clients.
- Exhibits skills in focusing on goal-oriented problem identification that leads to concrete solutions.
- Knows ethnic minority persons who have been successfully rehabilitated and can relate the experiences and success of these persons to others entering and/or involved in the change process.

This listing of effective knowledge, attitude, and skill factors is, of course, a tentative framework for stimulating examination of the provision of services by rehabilitationists to disabled persons from ethnic minority backgrounds, for suggesting training objectives and methods, and for stimulating research. Indeed, the listing itself can be an object of research, for items can be added, subtracted, and otherwise combined and so forth.

IMPLICATIONS FOR THE HOWARD UNIVERSITY PROJECT

Implications refer to initiatives needed to clarify or to make complete understandings that have been presented.

If the Howard University Model to Improve Rehabilitation Services for Minority Populations with Handicapping Conditions is to realize its objectives, then cultural factors will need to be emphasized in the project. Efforts will have to be made to facilitate sen-

sitivity to client needs and differences through training and appropriate educational materials. Efforts to improve access to the existing systems will have to be tried and assessed along with exploration of the feasibility of alternate service delivery systems. Research and dissemination of findings on some critical issues will be needed. The model must be both synergistic and transcendent.

Need to Emphasize Cultural Factors

Relating the recommendations given to nurses by Bauwens and Anderson (1984, pp. 256-257), to the Howard University Project, there will be a need to emphasize cultural factors, specifically:

- Be aware of the ethnic minority client's cultural interpretations of health and ability, illness and disability, and health and rehabilitation.
- Identify sources of discrepancies between clients and their rehabilitation helpers in the meanings of health and ability, illness and disability, health care and rehabilitation.
- Be aware of the cultural values that affect the interface with and use of the rehabilitation system by ethnic minority persons.
- Evaluate the effectiveness of rehabilitation helper actions with clients from diverse cultural groups.

Need for Nonracist Practitioners and Cross Cultural Training

The four specific characteristics of nonracist practitioners suggested by Solomon (1976, p. 313), need to be evaluated for effectiveness as training and service delivery objectives:

- The practitioner should possess the ability to perceive in any behavior—other's or one's own—alternative explanations for that behavior, particularly those alternatives which the self might strongly reject as false.
- The practitioner should possess the ability to collect objectively, through the senses, those verbal and nonverbal cues which would help to identify all possible alternatives to the one which is most probable for a given client.
- The practitioner should have the ability to feel warmth, genuine concern, and empathy of people regardless of their race, color, or ethnic background.
- The practitioner should be able to confront the client when true feelings of warmth, genuine concern, and empathy have been expressed but have been misinterpreted or distorted by the client. In brief, the rehabilitationist should have synergistic and transcendent skills related to productive confrontation of differences (p.313).

In considering the dynamics and benefits of intercultural development, attention should be given to the model presented by Gudykunst and Kim (1984).

In addition, the training procedures outlined by Triandis and Brislin (1984) for improving cross-cultural awareness and effectiveness need to be examined against the objectives of the Howard University Project. These procedures include: information or fact-oriented training; attribution training; cultural awareness methods; cognitive-behavior modification procedures; experiential learning strategies; and interaction approaches.

Need for Influencing Responsiveness in the Existing System and Determining the Viability of Alternate Systems

Efforts will need to be made to increase the responsiveness of the existing rehabilitation systems to ethnic minority persons by hiring more minority persons at professional and support levels; bringing services to the geographic areas of the clients; and establishing meaningful service delivery objectives, monitoring actions, evaluating results, and making modifications as a result of appropriate feedback.

In terms of alternate systems of service delivery, the recommendations provided by Gellman (1966) and Solomon (1976) need to be considered, particularly Solomon's suggestion about relating service delivery to religious institutions.

Need for Research and Dissemination of Findings

The research questions posed by Usdane (1965) nearly twenty years back are still relevant and need attention. In addition, five social psychological cultural issues delineated by Sue (1983) seem worthy of exami-

nation. These are: etic vs. emic, mainstreaming vs. pluralism, equal opportunity vs. equality of outcomes, modal personality vs. individual difference, and presence vs. absence of racism today. Other issues which need research are policy/practice changes and multiple service delivery methods and accuracy in the translation of similar concepts with different meanings.

Among variables which also need study are the congruence of perceptions, cognitions, and motivations of ethnic minority clients and rehabilitation helpers; effective and ineffective interpersonal interactions in counseling and the supervision of counseling related to ethnic minority persons; and group dynamics in relating to the extended families of ethnic minority clients.

From a methodological perspective, there is a need for participant observer and case study approaches as well as survey and experimental approaches.

In the dissemination of research findings, there will be a need to balance ideological and practical viewpoints. Some attention needs to be given to the development of dissemination specialists and dissemination networks.

Need for a Synergistic and Transcendent Model

In implementing and improving the model, attention needs to be given to the principles suggested by Brayfield (1964) in his article on human resources development and his emphasis on how learning is influenced by expectations, reinforcement, modeling, achievement motivation, and problem solving.

In addition, the currency of existing philosophic principles related to rehabilitation (Wright, 1959), and their relevance to the rehabilitation of ethnic minority persons need to be examined, and means for actualizing these principles need to be developed.

FINAL NOTES

I have been professionally associated with rehabilitation for twenty-six years, first as a rehabilitation counselor in a state agency serving the visually disabled, then as a rehabilitation psychologist at a hospital specializing in the care of chronically ill patients and the rehabilitation of persons with severe disabilities. This was followed by work as a rehabilitation professor at two universities and as dean for student affairs whose responsibilities included the delivery of services to disabled students and the coordination of the institutional self-study required in implementing 504 regulations at one of the universities. I have also served as a consultant to many different rehabilitation programs, as the president of a state rehabilitation association, and as an editor of rehabilitation newsletters and publications.

My interests in cross-cultural psychology and counseling have been longstanding and have carried me to Japan, Taiwan, Germany, Jamaica, and Brazil in consultative relationships.

From my vantage point, the initiatives to facilitate ethnic minority access to and development through rehabilitation services have failed to reach a critical mass. Indeed, while some gains obviously have been made, I often wonder if we are now on the defense in trying to preserve the limited gains we have made.

It is hoped that the Howard University Project will break this plateau, pull together, synthesize, and transcend past efforts to facilitate accelerated movement toward the objectives of equal access and benefits for ethnic minority persons with disabilities as these relate to rehabilitation. This project would make a lasting difference in the quest of ethnic minorities for effective rehabilitation services.

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10 • Socio-Economic and Cultural Problems Affecting the Delivery of Rehabilitation Services to Hispanic Blind and Visually Disabled Individuals—Some Observations

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Abstract

The author discusses the problems associated with rehabilitative service delivery to blind and visually disabled Hispanics. Communication barriers are cited as a major problem. The need for an understanding of Hispanics' cultural background, family loyalties in terms of their effect on service delivery to the group, and the acceptance of rehabilitation is also discussed. The State Commission for the Blind of Texas has made significant gains in recruiting and employing professionals to meet the needs of the blind and visually disabled Texans.

There is a common assumption that Hispanics are not amenable to therapy or counseling; that they do not possess the motivation necessary to enter into a counseling situation with expectations of receiving benefit from the service delivery; and that they will not contribute to the success of their rehabilitation program. In reality, Hispanics will accept help, counseling, and services if their cultural identity is respected and their individuality is maintained and recognized. In the area of rehabilitation services for the blind and visually disabled persons, the State Commission for the Blind of Texas has worked steadily toward the development and

implementation of a service delivery system that effectively meets the needs of all blind and visually disabled Texans. Recognizing that blindness, like other disabilities is no respecter of ethnic origins, the agency's vocational rehabilitation efforts are based on a need to serve Hispanic clients in a manner that will produce the greatest results for the client.

Recognizing that language is one of the most obvious manifestations of any culture, vocational rehabilitation professionals (teachers and counselors) must acknowledge the crucial role this plays in service delivery to blind and visually disabled persons who are Hispanic. The overall importance of culture in understanding, regulating, and examining human behavior and reactions to a disability such as blindness cannot be overstated. The basic assumptions underlying most intervention efforts are exemplified by programs that either deny certain aspects of the Hispanic culture or propose corrective measures that separate the individual from his or her cultural background. The raising of the cultural sensitivity of professionals involved in the vocational rehabilitation field is a necessary step towards providing culturally valid services to the Hispanic community. Integral to the understanding of the Hispanic disabled person is the need to understand the impact of language and culture on that individual. Studies spanning nearly half a century have consistently shown that the Hispanic population is this nation's most undereducated minority. In many ways, they are also this nation's most misunderstood ethnic group. To put it as another author did, "monolingual, English-only instruction has had at least as devastating an effect educationally on Hispanics as slavery and segregation had on Blacks" (Yzaguirre, 1981).

BARRIERS TO REHABILITATION

To some extent, the Hispanic outlook on life is reflected in the Spanish language. One Hispanic author wrote, "We tend to be very gentle with ourselves, using the diminutive when talking about ourselves and our dear ones. We approach a level of gentleness and tenderness which is unique to our people" (Enrique, 1980). In the balance of understanding stress and pain, mental health problems, aberrations in behavior, or even disabilities such as blindness, it is quite common to hear a Spanish-speaking person refer to a blind individual as "un pobre ciegito" (a poor blind man). Illness, faults, and even disabilities become extensions of the person and are oftentimes treated with nurturing, sympathetic kindness, and comfort. Many times, this protective covering poses a problem for vocational rehabilitation counselors or teachers who are trying to move the blind person toward independence and a maximum level of self-sufficiency that may be afforded through employment assistance efforts that allow the blind person to secure a job.

Oftentimes, family loyalties and other cultural factors (including religion) foster dependency and isolation. To members of the rehabilitation agency, such as the Texas Commission for the Blind, this poses added challenges in working with Hispanic clients who are hesitant to accept the training and counseling needed for their rehabilitation. In the rural areas in Texas, for example, vocational rehabilitation teachers and counselors must deal with the fact that Hispanic clients are oftentimes unwilling to leave their home area for specialized training and employment opportunities. There is a tendency by family members to protect the blind relative and keep him or her close by. The basic tenet of vocational rehabilitation, that of "independence," then becomes a sensitive issue when dealing with the client and the family members. It becomes crucial for the vocational rehabilitation worker to explain the value of independence for the disabled person without startling family members or attacking the role that the family plays in this culture.

Several other key issues surface when dealing with Hispanic blind clients. Before anyone can examine the uniqueness of disabled Hispanics, it becomes vitally important to examine the following factors:

- —the role of "la familia" in the Hispanic culture
- —the traditional views of disabilities and attitudes toward rehabilitation, independence, and counselor/client roles
- —the impact that a disability such as blindness has, not only on the individual but on the family unit
- —the complications of poverty, minimal

education, and language barriers on the success of a rehabilitation plan
—the role that religion, folk healers, and other sources of support play in meeting the disabled person's needs.

There is no question that delivering effective vocational rehabilitation services to blind and visually disabled Hispanic clients is a challenge to any professional. Efforts in Texas, through the State Commission for the Blind, have centered on the need to recruit and employ qualified professionals who either have a Hispanic background or an understanding of this group's cultural foundations. Approximately 20% of the agency's staff is Hispanic. With offices located throughout the state, the Commission maintains operations in areas that are predominantly Hispanic and are served by agency personnel equipped to meet special needs.

Vocational rehabilitation (VR) personnel employed by the Commission serve approximately 35-40% Hispanic clients on agency caseloads. While most of these individuals are located in the Rio Grande Valley, El Paso, Laredo, and San Antonio, large pockets of Hispanics are located throughout the state and on caseloads served by the Commission. Individuals working with Hispanic clients must readily recognize that their approach to VR must be tailored to the client's needs. In the case of Hispanic clients, VR professionals must place a strong emphasis on the involvement of the family throughout the entire process of rehabilitation. Staff must recognize the customs and values of Hispanic clients so as not to antagonize them and reduce the chances for success during the entire rehabilitation program. It is just as important to recognize the traditions and norms so as not to get bogged down on a traditional methodology to the exclusion of results. Finally, it is incumbent upon the VR teacher or counselor to want to learn and understand the social and cultural configurations of Hispanic clients.

The uniqueness of the vocational rehabilitation program as compared to other social service programs rests on a proven service delivery model that requires maximum participation during each step of the process by both the client and the VR professional. The direct benefit of the VR program to society is reflected in the fact that there is more than a nine to one dollar return on every tax dollar spent. How these services are offered to Hispanic blind persons is an issue that continues to draw added attention.

While there is no proven formula for an effective approach to working with Hispanic disabled persons, organizations such as the State Commission for the Blind in Texas have found that one of the most appropriate means is to employ professionals who possess a valid understanding of this culture. The issue of language barriers is quite obviously an important consideration to the establishment of an effective service delivery system. The attitude that Hispanics have toward dealing with their disabilities must also be considered and woven into the service delivery modality. Also, there must be a continued emphasis on forums of this nature that will allow for open dialogue and exchange of ideas concerning the needs of disabled Hispanic citizens and effective means of delivering rehabilitation services.

This presentation could not be complete without an account of an incident that captures the essence of this issue, particularly as it relates to the importance of language and working with Hispanic clients. The story goes something like this: A VR teacher working with the Commission for the Blind recalls the time she went to visit a Hispanic family on her initial contact. She did not know that the family was fluent only in Spanish, and she was not prepared for what was to come. Upon arriving at the home, the teacher knocked on the door. When greeted by one of the family members, the teacher thought it would be a good opportunity for her to test her limited Spanish. When asked who she was, she responded: "I'm from La Comision De No Ojos." Quickly this sent a chill down the spine and soon several people were at the door with a definite sense of alarm. Who was this person who acknowledged herself as being a representative of an agency without eyes? Was she there to remove someone's eyes? What the teacher meant to say was: "I'm with La Comision Estatal Para Los Ciegos."

After awhile, both the client and other family members understood that the stranger was there to do an initial interview and to ascertain what types of services the Commission could offer to one of their family members who was blind. They soon realized that the purpose of the visit was not to remove someone's eyes.

Looking back, there is obviously some humor in the embarrassing situation. However, viewed in a different and more serious vein, the entire situation points out a rather significant aspect involved in dealing with persons of the Hispanic culture who adhere to their native language.

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11 • The Emerging Role of the Disabled Hispanics

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Abstract

The state of "double jeopardy" which disabled Hispanics are in is discussed in this article. The economic, social, and educational problems of the increasing population of Hispanics in the United States suggest the need for more meaningful rehabilitation services. The author outlines factors affecting rehabilitation: the role of the family; personal network among Hispanics; the male attitude; intake procedures; and language barriers. Evidence in support of the critical need for bilingual, bicultural rehabilitation professionals is provided. The author concludes by listing the recommendations from the conference on the Special Rehabilitation and Research Needs of Disabled Hispanic Persons in 1983.

The term "Hispanic" represents diverse populations that include, in large numbers, Mexican-Americans, Cubans, Puerto Rican mainlanders, and Puerto Rican islanders. As noted by Linsky, Arnold, and Hanoch (1983), cultural differences can be assumed to exist among the various Hispanic populations. Further, it seems reasonable to hypothesize that such cultural differences between and among Hispanic populations are historical in origin, but are also affected by geographic region, socioeconomic status, educational level, and rural-urban locale. Therefore, it becomes imperative to scrutinize closely all research which presumes to reflect the "Hispanic" culture.

Hispanics constitute a growing population in the United States. The 1980 census indicated a substantial increase from previous years. They now number in excess of 14½ million and represent a significant proportion of the American population.

However, data on the number of Hispanic disabled is practically non-existent. Based on limited data and using inferential methods, it is estimated that there are 2.5 million Hispanics of working age who are disabled. However, only 25,000 persons of Hispanic origin were rehabilitated by public programs in 1981.

The Hispanic disabled represents a real challenge to rehabilitation professionals and administrators. If we are to provide meaningful rehabilitation services, we must understand the cultural characteristics discussed by Rivera and others.

La Familia: The Spanish family provides the primary support system for the individual. Despite the many positive factors of family support systems, one drawback is the occasional overprotectiveness that tends to dilute efforts towards independence by disabled individuals.

Personalismo: This relates to the personal network among Hispanics as opposed to the dependence on institutionalized direct delivery systems. The absence of Hispanics in key positions mitigates against an effective delivery system because of their reliance on personal contacts and acquaintances. Thus, many Hispanic clients are reluctant to share relevant information with non-Hispanic rehabilitation counselors, since the latter is perceived to be an "outsider."

Machismo: The male attitude of full responsibility for behavioral guidance of the family. Within this context the male member of the family is responsible for providing resources to the family and for making major decisions affecting the family members.

La Palabra: "A man's word is his honor." The commitment to a verbal contract is very important to Hispanics. Performance based on one's word as opposed to written contracts is of paramount importance and should be considered in any rehabilitation program initiated on behalf of Hispanics.

Language: There is limited information available in Spanish regarding the vocational rehabilitation program. The communication barrier is critical since there are so few bilingual and bicultural professionals in rehabilitation.

Clearly, the emerging issues in our efforts to serve this population revolve around 1) existing barriers to rehabilitation; 2) development of innovative service delivery systems; and 3) basic research issues. Of particular concern, however, to rehabilitation practitioners is the need to develop specialized programs to overcome immediate barriers to rehabilitation and employment.

A paper by Rivera (1983) (published in the reprint from the Mary Switzer Memorial Monograph entitled Social implications for rehabilitation planning: Blueprint for the 21st century) summarized the situation in the following manner:

> There appears to be an underutilization of rehabilitation services by disabled Hispanics. The reasons for this is the barrier to access to these services. The solution is the need for outreach and advocacy. Rehabilitation counselors need to go into the community (including the home) and get acquainted with community leaders, and the clergy, informing them of what rehabilitation services exist for disabled persons and how to access the system. All too often potential clients do not understand the application process to enter a vocational rehabilitation program nor their rights as citizens under the rehabilitation laws and regulations.

One obvious solution is to train more bilingual, bicultural professionals and place them in areas where there is a high concentration of Hispanics.

Lafitte (1983) recommends that current training programs in rehabilitation introduce into their curriculum undergraduate and graduate courses in the language and culture of Hispanics. Such course offerings would be of significant value to rehabilitation training programs located in areas with a high concentration of Hispanics (e.g. southwestern United States, metropolitan New York City, southern Florida, and Puerto Rico). Lafitte also champions an assertive and well-organized recruitment program to attract Hispanics into their rehabilitation training program.

A conference on the Special Rehabilitation and Research Needs of Disabled Hispanic Persons (1983) provided a variety of recommendations regarding rehabilitation issues and research needs. Several of these needs are listed here:

1) More accurate data on the numbers, types of disabilities, and acceptability of services in order to design effective rehabilitation services for the disabled Hispanic person.

2) Research on the effectiveness of various rehabilitation approaches to eliminate barriers which preclude acceptance and utilization of rehabilitation services and technology by this population.

3) Research of innovative approaches to extending rehabilitation services to migratory workers and disabled who live in rural areas.

4) Research should include elderly Hispanic persons whenever rehabilitation issues are addressed.

5) Development of mechanisms for involving the disabled Hispanic student in the rehabilitation process prior to the end of his or her secondary school education.

The above are but a small number of ideas for programs that need to be undertaken but one other important need exists. The inability of many Hispanics to communicate easily in English seriously obstructs access to rehabilitation services and employment.

For many disabled Hispanics, the educational stability so essential to learning English is often missing. This problem is twofold and solutions must be sought from a dual perspective. Knowledge of English as a second language must be pursued and more bilingual and bicultural services must be available from the providers of rehabilitation services. This is certainly an attainable goal by the year 2000.

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